Recipient Registration Form

Fields with an * are required

_____

***First Name**

_____

***Last Name**

_____

***Street Address**

_____

***Town/City/State/Zip or Postal Code**

_____

Phone Number

_____

Cell Phone

***Gender**

- ☐ Female
- ☐ Male
- ☐ Decline to Specify
- ☐ Other

***Date of Birth** *Click or tap to enter a date.*

***Ethnicity**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown/Not Reported

***Race** (Please check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Unknown/Not Reported

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Emergency Contact Name

Emergency Contact Number

***I am currently living in a nursing home**

- ☐ Yes
- ☐ No

***Select Priority Group**

- ☐ Adult with comorbidities or other medical conditions
- ☐ Age 65 and older
- ☐ Deployed and mission critical personnel for national security
- ☐ Education sector personnel
- ☐ Emergency service and public safety sector personnel
- ☐ Food & agriculture & transportation sector personnel
- ☐ Health care providers in long term care facilities (LTCFs)
- ☐ Inpatient healthcare providers
- ☐ Live with or care for adult 65 and older
- ☐ Long term care facility residents
- ☐ Manufacturers of pandemic vaccine and other critical pandemic therapeutics
- ☐ National Guard personnel
- ☐ Other congregate living facility residents
- ☐ Other priority groups
- ☐ Pharmacists and pharmacy technicians (Retail)
- ☐ Public health personnel

***Organization Name**

Organization Street Address

Organization City/Town, State, Zip Code